## **Louisiana State Board of Medical Examiners**



630 Camp Street, New Orleans, LA 70130 Phone: (504) 568-6820; Fax: (504) 568-5754 Web site: http://www.lsbme.la.gov

## **COMPLAINT FORM**

2. Address and telephone nu	umber of complainant:		
Address:	City:	State:	Zip:
Day phone #:	Evening Phone #:	Email:	
3. Relationship of complains	ant to patient:		
4. Name and Date of Birth of patient: Name:		Date of Birth:	
	practitioner about whom you are complain professional about whom you wish to con		omplaint form for each
Name:			
Address:	, City:	State:	Zip:
Phone #:			
Approximate dates of treatm	nent: From: To:		
Complainant's Signature		Date	

## **Louisiana State Board of Medical Examiners**



630 Camp Street, New Orleans, LA 70130 Phone: (504) 568-6820 Fax: (504) 568-5754 Web site: http://www.lsbme.la.gov

## **AUTHORIZATION TO RELEASE YOUR COMPLAINT INFORMATION**

I hereby give the Louisiana State Board of Medical Examiners permission to send a copy of my complaint to the practitioner listed below and that this will include disclosing my identity. I understand as well, whether I sign below or not, that the medical records of the patient(s) involved may be obtained by the Board as a part of its investigation.

I may elect not to sign below and thus request that my identity be kept confidential. In that case, a summary of the complaint may be provided to the practitioner. I understand however, that even if I do not sign below and have the Board handle this complaint confidentially, that the Board may be required by law to disclose my identity to the practitioner at a later stage of the proceedings.

Understanding the above, by my signature below, I hereby give consent to the Board to release a copy of my complaint to the practitioner/licensee:

Practitioner/Licensee's Name:	<del>-</del>
Business Address:	
City, State, Zip Code:	
Complainant (print name):	
Complainant's Signature:	Date: